

## Commentary

# When "Culture Trumped Safety", Developing a Protective Weave in Child Welfare Organisations: A Case Study

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The Royal Commission into Institutional Responses to Child Sexual Abuse has uncovered evidence that organisations sometimes provide opportunity for the sexual abuse of children. How do organisations go about preventing this? The authors of this paper consider the case of an out-of-home care (OOHC) agency which failed to protect children. By identifying gaps in practice and culture in this case, the authors suggest that protecting children in OOHC requires a "weave" of organisational structures, staff development and cultural competence. In this case, the Chief Executive Officer (CEO) of the organisation was able to create an opportunity for access to vulnerable young people by using strategies we can now identify as grooming behaviours. He did this by using his positional power. He ignored standards, isolated protective adults and therefore children and young people, rewarded compliance, discouraged reflective practice, used his culture to avoid scrutiny from funding and oversighting agencies, and created an organisational culture of fear and secrecy. In effect, he used culture to trump safety. Even in the stressful conditions of managing an OOHC service, good practice is important, not only because it meets the standards and legislation, but because this is how services maintain the safety of children and young people in care.

■ Keywords: Child protection, organisational culture, Indigenous children, child safe organisations

#### Introduction

Wikipedia provides a definition of weaving as "... a method of fabric production in which two distinct sets of yarns or threads are interlaced at right angles to form a fabric or cloth... The method in which these threads are interwoven affects the characteristics of the cloth."

In this paper, we will use the idea of weaving threads together to create a strong fabric as a metaphor to consider how OOHC agencies can reduce the opportunity for child abuse. The threads include organisational culture, structures and processes, worker knowledge and skills and cultural competence. When these threads are woven together, they provide a fabric which will reduce the opportunity for abuse of the children and young people in care.

The Royal Commission into Institutional Responses to Child Sexual Abuse has identified a number of cases of organisational-based sexual abuse of children. This paper will consider one of these case studies and examine the "threads" identified above. In this case study, the perpetrator who was arrested for possessing child pornography, was the CEO of an agency that case managed children who had been removed from their parents.

This case study will not focus on the assault of the children and young people, although the authors acknowledge the pain and trauma suffered by the children and young people who were sexually assaulted, and are distressed by what has happened to those young people in this situation. Rather, the authors will highlight how weaknesses in this organisation were created and exploited to provide opportunity and access to young people who had been abused or neglected and were already very vulnerable. The authors also acknowledge the burden of race carried by other Aboriginal communities through which the actions of one individual can reflect badly on Aboriginal people and services.

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In this case, the CEO used the authority of his position to develop an organisational culture that allowed access and opportunity to abuse children and young people, and used his aboriginality to shield his actions from organisations, such as the OOHC oversight and funding agencies, that usually provide monitoring and protective capacities. The authors hope that by examining this case, it will encourage other OOHC agencies to develop strong threads of policy, processes, clinical and cultural competence to weave together a fabric that will protect children and young people.

### **Background to this Case Study**

The agency was a small, non-government organisation run by Aboriginal people to provide OOHC to Aboriginal children and young people in the Hunter Region of NSW. It was one of the first Aboriginal community controlled OOHC agencies funded in New South Wales. The agency had strong standing and ties to the local Awabakal and Worimi Aboriginal communities. It was a pioneer service funded for over 20 years with a community Board and a majority of Indigenous staff ranging from 15 to 30 people over the years. By 2011, there were 50 Indigenous children foster care placements, casework and supervision, plus foster carer recruitment, training and support.

The agency website identified the organisation's main functions as being to "... provide foster care to Aboriginal children and young people of the Hunter Region and to support the families (Aboriginal and non-Aboriginal) of those Aboriginal children. As well as providing support to Aboriginal families in crisis and young people at risk of involvement with Juvenile Justice." The main objective of the service was to "... to keep Aboriginal children safe.... by supporting Aboriginal children, young people and their families."

The sources for this article include information from agency documents and unpublished discussions between the authors and workers from the agency after the event, as well as media reports, transcripts and reports from the Royal Commission into Institutional Responses to Child Sexual Abuse and other publications.

The authors were each employed with this agency as consultant social workers after the arrest of the CEO. Karen Menzies is a social worker and lecturer at the Wollotuka Institute, University of Newcastle. She also provides consultancy and training in child protection, trauma and the traumatic impact of the past legislation on Aboriginal and Torres Strait Islander people. Karen is a Wonnarua woman and was the social worker on the Human Rights Commission team. She heard testimony from hundreds of Aboriginal and Torres Strait Islander people who had been forcibly separated. She is currently undertaking her PhD on understanding the framework of the Aboriginal experience of "Assimilation as Trauma: Implications for welfare practitioners in the child protection system".

Karen was contracted by the agency immediately following the arrest of the CEO to provide debriefing, support and training for the staff who were shocked and distressed by the revelations.

Lyn Stoker is a social worker and lecturer at the Family Action Centre at the University of Newcastle. She also provides consultancy for OOHC and other non-Government organisations. She has worked in Heath and in Community Services and is particularly interested in child focused practice and learning at work. Lyn is not Aboriginal or Torres Strait Islander. Lyn worked with the agency some months after the arrest to assist the organisation to look at systems and processes required to attain accreditation from the Office of the Children's Guardian. Unfortunately, this was never achieved and this service closed in 2012.

# Sexual Abuse of Children and Young People

Many authors have described the tactics used by perpetrators of sexual abuse. (Conte, Wolf, & Smith, 1989; Craven, Brown, & Gilchrist, 2006; Foote, 1999; McAlinden, 2012; Miller, 2013; Mooney & Ost, 2013). This work identifies that sexual offenders use tactics to select victims, often vulnerable children, and engage them in a process leading to sexual abuse known as grooming. The literature identifies that sexual offenders also use those same tactics to manipulate the environment of the child and significant adults (Craven et al., 2006).

Many offenders seek access to their victims through their employment (McAlinden, 2012), and they seek public positions in an effort to make themselves helpful and indispensable, if possible. McAlinden refers to their skill in grooming entire organisations, including using their positional power and authority, which is reflected in this case study. Children in care are especially vulnerable as they have already experienced trauma and/or abuse (McAlinden, 2012).

Generally, a child's world is full of connections — to their parents or carers, siblings, extended family, friends, school teachers and fellow students, local community, sporting teams etc. Even if they had these connections previously, children in OOHC have many of these relationships severed when they were placed in care. They already have had their communication links weakened and their relationships narrowed. It is easy for a perpetrator who is in a caring role to further reduce the child's relationships with others. Agencies with case management responsibilities of children in care have to take this increased vulnerability into account.

The standards in OOHC (Office of the Children's Guardian, 2013) are very clear about the requirements for caseworkers to visit and have regular communication with children and young people in care. Agencies are also directed to have representation from all the people and agencies in a child's life. This can include birth parents, extended family, school, health services, sport or clubs etc. This broad participation in case planning and management is one of the ways

to strengthen the safety net around the child. The case plans from the Agency indicate that this was not routine and, in fact, rarely happened. Many of the children and young people became increasingly isolated as these Standards were not met. The lines of communication become increasingly narrower and controlled by the perpetrator. The CEO took on additional "responsibilities" with the children in care of the agency (for instance, taking parental responsibility for specific children) and was able to effectively control the children and young people's communication links in their personal world. He also controlled the links between them and other people who had a role in protecting these children.

In any organisation, there should be a series of checks and balances. In this case, it seems practices that would be deemed unacceptable from other organisations, were overlooked by those responsible for oversighting and funding for a number of years. It seems that the usual checks did not take place, were subverted or did not identify the problems.

### Indigenous Out of Home Care

Aboriginal workers in the child protection and OOHC sector, are deeply affected by their own and their families' experiences of, and legacy from, the past laws, policies and practices aiming to achieve assimilation. This series of interventions explicitly aimed to "deculturalise" Aboriginal children in order to assimilate them into the dominant Anglo culture (Atkinson, Nelson, & Atkinson, 2010; Human Rights and Equal Opportunity Commission, 1997). The residual impact for Indigenous workers means they are fiercely protective of Aboriginal children to ensure they do not suffer the abuses of the past or experience further loss of culture and identity. OOHC workers generally are extremely conscious of the importance of safety and wellbeing and, in addition, Indigenous workers are very protective of Aboriginal children in care (Menzies & Gilbert, 2013). It was reasonable for the staff, Board and community to assume the CEO of this agency shared this commitment.

The rest of this article will examine some of the factors that led to the protective fabric of this organisation being so compromised. More specifically, we consider three threads that should be woven into the fabric that would protect children and young people. These threads are the organisational systems and processes, professional knowledge and skills and cultural competence.

## Organisational Systems and Processes

It is useful to examine the principles of good organisational culture and structures as a first step in considering what may have gone wrong in this agency. There are many books, articles and websites devoted to describing the principles of a well-functioning organisation and, more specifically, examine those principles in relation to welfare and not-for profit agencies (Aldgate et al., 2007; Bullen, 2013; Coulshed & Mullender, 2006; Ginsberg & Keys, 1995; Innovation & Business Skills Australia, 2011; Reconciliation Australia

n.d.). In addition, there are national and various state-based standards relating to OOHC (Department of Communities, Child Safety and Disability Services, 2010; Department of Human Services, 2012; Department of Social Services, 2011; Office of the Children's Guardian, 2013).

These documents differ in focus and detail, but there are some common themes. The *Indigenous Governance Toolkit* (Reconciliation Australia, n.d.) lists the important ingredients of good governance as people, processes, strategies, resources, culture and environment. *Management in social work* (Coulshed & Mullender, 2006) lists cultural change, leadership, people diversity; while the learning organisation literature focuses on people and culture (Hailey & James, 2002). The similarities include clarity of roles and responsibilities, processes and systems in place to ensure accountability for the organisation as a whole, development of the people and an explicit ethical framework. It is useful to examine how these principles played out in this agency.

#### Governance

"Good communication, trust and mutual respect between a governing body and its senior management are essential for effective governance." (Reconciliation Australia, n.d.). One of the safeguards for community organisations is to have a well-functioning Board or Management Committee that provides strategic leadership and oversight. The agency in question had a community representative board for the most part selected by the CEO. The Royal Commission commented that for the most part, people on the Board did not have specialised knowledge in OOHC or organisational management. Furthermore, the CEO was the only link between the Board and the rest of the organisation. The Board members questioned by the Royal Commission did not seem to understand their organisational, legal or ethical obligations (Royal Commission into Institutional Responses to Child Sexual Abuse, 2014b: Transcript day 5, p. 407-408). If this was the case, it would be difficult for the Board to provide either strategic vision or oversight.

The Board and staff have identified that the CEO was the focal point for all communication and that he was consistently the main source of information to and from the Board. "(he)... separated the staff from the committee. The staff weren't allowed to speak to the committee, and the committee weren't allowed to speak to the staff." (Royal Commission into Institutional Responses to Child Sexual Abuse, 2014b: Transcript Day 4, p. 391). Staff and the Board members felt they had nowhere to go with any questions, let alone complaints or issues. All issues had to be raised with the CEO who then decided what would happen.

The Royal Commission also noted that some Board members, staff and carers were related to the CEO. This is unusual in non-Indigenous organisations and so is worth comment. The Aboriginal community is relatively small and Aboriginal extended families are large. Community based organisations will often include people who are related. The

authors recognise that family and kinship relationship is a strength of Aboriginal workers and provides important links to their community. This needs to be acknowledged and valued. So, it is not that an agency should be judged for having family-based relationships between staff, but rather that when this occurs it should be managed in an ethical way and with a clear and transparent process. This would include ensuring that the right people for the job are recruited and that family relationships do not result in favouritism or fear.

#### Staff Employed by the Agency

The staff of an agency is a core resource and so the management of those workers is integral to a high-functioning organisation. There are three main components of this: matching people and jobs, providing supervision and ensuring staff development (Bullen 2013; Coulshed & Mullender, 2006; Fox, 2011). The literature suggests good practice relating to people will build commitment and motivation and improve learning in the organisation. The management team underneath the CEO reported that they were not selected on the basis of management knowledge and experience; nor were they provided with management training or professional development. There was almost no structured or professional supervision. This was not an organisational culture that valued learning, innovation, improvement and sustainability. Staff were encouraged to be obedient and compliant with the CEO directives and, for the most part, had no real decision-making power or capacity to question directives. Training was seen as a reward or a boon of "time out" provided by the CEO, rather than an opportunity to improve practice or develop knowledge and skills.

Workers reported that there were almost no human resource systems and processes in place. For example, different workers with similar positions were on different salary rates, compliance was rewarded by promotions and salary rates changed and minimised for those who questioned the CEO. Employment was not merit based and workers spoke about how the CEO would "keep them busy" with additional tasks if they questioned him (about any organisational or procedural issues).

The Royal Commission has documented that the Working with Children's Check system was not implemented properly in relationship to the CEO, by the CEO himself or the Board, The NSW Department of Community Services or the Commission of Children and Young People (Royal Commission into Institutional Responses to Child Sexual Abuse, 2014a, p. 27–29). It is reasonable to wonder if it was implemented properly for others involved in the agency.

Kinship and foster carers, although not staff precisely, make a huge contribution to any OOHC agency. In this agency, the carers were hand-picked by the CEO. The records indicate that there was no standardised assessment process, no working with children's checks and no regular reviews of carers. There was little training or support provided to carers. There were some cultural activities organised, but

these were designed largely "in house" and were not based on partnerships with other organisations, increasing the isolation of the children and young people, and of the carers and the community.

#### Communication, Policies and Processes

Strong communication strategies and shared knowledge are another way to build organisational strength. In this case, it seems that secrecy and the rigid control of information was the standard operating practice. This had an impact on the organisational culture and weakened the protective weave. As noted by many authors, "child sexual abuse thrives on ignorance and secrecy" (Conte et al., 1989; Craven et al., 2006; Foote, 1999; Miller, 2013). It is worthwhile, then, to examine the communication processes. The staff reported that all negotiations and communication with external agencies were managed by the CEO with other staff having almost no formal communication channels outside the agency.

Staff reported that they were told by the CEO that the organisation was highly respected and a model of good practice and that they were well in "advance" of other OOHC agencies seeking accreditation (apparently not a position shared by agencies deciding on accreditation).

Good practice also includes adequate and appropriate processes and systems in place for data collection and information, communication and human resources. In addition to general policies, a recent article by Tucci, Mitchell, Holmes, Hemsworth and Hemsworth (2015) identifies that organisations should also have child protection policies to strengthen their capacity to protect children from harm. In this agency, staff reported that policies and procedures, for the most part, were missing, inconsistent, unavailable and, in general, did not meet the NSW OOHC standards (or the guidelines set by other states) previously cited.

It can be argued that the lack of policies and processes, the CEO's tight control over communication and a Board and staff who were not encouraged to learn and develop their knowledge and skills all contributed to weakening the protective weave around children. This is not to imply that the staff were in anyway compliant in relation to the child sexual assault, but rather were caught up in the web of deceit. It can be argued that the staff, the Board and the broader community were in fact groomed. As in the case of familial non-perpetrators, they were isolated and caught up in the "beliefs, threats and fear" propagated by the perpetrator (Foote, 1999, p. 76). The lack of policies and systems contributed to isolating the child victims by isolating and undermining the adults around them.

What has also become clear is that the failures of systems and processes were not only to be found within this agency. The Royal Commission report highlights "... systemic failures allowed a paedophile, ... to operate unchecked for almost 15 years, first as a Scout leader and then as the head of ... (this) Service". The reasons for such widespread failure need to be further considered.

# Clinical Competence – Knowledge and Skills Required for Good Practice

There are many documents outlining good practice in social work, welfare work and in child protection and OOHC. The Australian Association of Social Workers (AASW, 2013), Community Services (Community Services, 2004), OCG (Office of the Children's Guardian, 2013), all have "good practice" descriptions on their websites relevant to OOHC. For example, the AASW lists the components of good practice as professionalism, culturally responsive and inclusive practice, specific knowledge related to practice, information recording and sharing, professional development and supervision (AASW, 2013).

The national competency guidelines (Department of Education, Employment and Workplace Relations, 2011) outline the knowledge required to be deemed competent in OOHC. This includes knowledge of:

- Relevant legislation.
- Indicators, effects and dynamics of abuse and neglect.
- Responsibilities of duty of care.
- Roles and responsibilities of each of the key players in the child protection area.
- Organisation protocols relating to child protection work.
- Effective stress management techniques.
- Legal implications and responsibilities of statutory work.
- Relevant policy and procedures.
- Stages of child development (Physical, cognitive, emotional and social).
- Interview processes and legal requirements.
- Effects of removal, incarceration.
- Parenting and family dynamics in different cultures.
- Impact of Government Policies on indigenous communities, e.g., Stolen Generations.
- Case management processes.
- Child centred family focused practice approaches.

The appropriate skills are listed as:

- Interpret policies, procedures, standards and statutory obligations.
- Communicate effectively with clients and significant others.
- Demonstrate active listening, reflective, summarising questions and statements.
- Demonstrate empathy and rapport building.
- Use age appropriate language and questioning techniques.
- Demonstrate conflict resolution.
- Manage grief and change processes.
- Work with adolescents and their significant others.

What is increasingly clear is that child protection, OOHC and child welfare practice, more generally, also need to be trauma informed (Blaustein & Kinniburgh, 2010; Friend, 2012; Golding, 2007; Herman, 1998) both for the long-term wellbeing of children and young people and to protect the wellbeing of workers by managing vicarious trauma (Figley, 2013; Mathieu, 2012). Knowledge about trauma and trauma informed practice is increasingly considered as part of the theoretical basis for anyone working with children in OOHC (Golding, 2007; Perry, 2009; Schore, 2001). It is especially important to understand the impact of trauma related to assimilation which was experienced by the Stolen Generations and continues to have a significant impact in the present for families and individuals who were forcibly removed because of their Aboriginality. "The benefit of carefully unpacking the correct story of Australia affords Aboriginal and Torres Strait Islander people their rightful place to be acknowledged and honoured for their experienced and resilience." (Menzies & Gilbert, 2013, p. 61). Intergenerational trauma continues to have impact for their children and grandchildren. Atkinson (2002) writes about the Aboriginal experience of forcible separation and assimilation and the resultant trauma that exists in many Aboriginal communities today. Menzies and McNamara (2008, p. 46) state, "every single Aboriginal person is directly affected by the separation policies, practices and laws, and continues to feel the effects of trauma and loss."

As previously referred to, it is the manager's responsibility to "... acquire, train and support the right compliment of staff... they must also ensure that staff are kept up to date (Aldgate et al., 2007, p. 141).

Staff of the agency in this case study reported that there was little provided in the way of supervision, knowledge development or professional development. Staff were not systematically provided with training in child development, child abuse and neglect, grief and loss, trauma, interagency roles and responsibilities in child protection, although the authors of the standards cited above include these as key elements of good practice. Some staff were employed in clerical roles and then moved into caseworker roles without necessarily any additional training. Managers were not provided with management specific training such as supervision or critical practice. In a classic case of "you don't know what you don't know", staff were unaware these even were good practice requirements until after the CEO was replaced.

In this case, staff did not consistently have even basic level knowledge and skills. In order to provide quality care trauma, informed practice needs to be woven into the service support for children in OOHC and for Aboriginal families and carers especially.

### **Cultural Competence**

Cultural competence is more than a commitment to engage respectfully with people from other cultures. Cultural competence can be seen as a set of system-wide behaviours,

attitudes and policies (Dudgeon, Milroy, & Walker, 2014; Farrelly & Lumby, 2009). Herring, Spangaro, Lauw, and McNamara (2013, p. 111) go further to say that "... the cultural competency frame needs to be reshaped so that mainstream services can both recognise the extent of trauma and racism, as well as identify culture as part of the living context of all individuals." (This applies not only to individuals and front line agencies but even to large government departments (Herring et al., 2013, p. 113).

Cultural sensitivity, culturally aware and culturally competent practice are essential for every service and organisation and not just Indigenous organisations. There are culturally based practices and concepts that are important to understand when working with Aboriginal children and families. There is experience and understanding that Indigenous workers can bring to an agency, and non-Indigenous workers need to acknowledge this in order to support to Indigenous clients (Bamblett & Lewis, 2006; Herring et al., 2013).

The authors accept this position on cultural competence, but seek to clarify the role of cultural competence (or incompetence) in our case study. Is it possible to use culture to avoid scrutiny? Chris Sarra spoke about the issue of Aboriginal leadership issue as part of an ABC radio interview (Radio National, 2014). In his view "... one can observe three categories of (Aboriginal) leadership: those who focus on being the victim; those who focus on booting the victim; and those who focus beyond victim status, or what I would call 'Stronger Smarter' leadership." If the Aboriginal CEO of an organisation argues that they cannot be accountable in the same way as others in similar positions, is this a case of using "victim" status? It can be argued that oversight agencies accepted this position and over the years did not provide the scrutiny applied to other agencies and so did not protect the young people in his care.

Racism is a complex and evolving concept and there are many different aspects of racism in practice. One version of this is a naïve acceptance that everyone who comes from the non-dominant culture is culturally competent and must be working for the good of their community. Another version is that one individual speaks for all individuals in a culture. Yet another version is that people from the dominant culture (in this case non-Aboriginal) do not expect other cultures to be accountable in the same way as the dominant culture. Marcia Langton has described this phenomena as... "Indigenous exceptionalism": a legal and policy attitude that expects Indigenous inequality and failure. The "soft bigotry of low expectations" has thus become a self-fulfilling prophecy in Indigenous affairs (Langton, 2012, Lecture 5)

Chris Sarra was talking about education, but the principle applies in other contexts when he said "A tendency for low expectations still pervades, often cloaked in a well-intentioned but misguided belief to protect Indigenous culture and communities....including a crippling lack of belief in their ability to succeed... At best it's naïve, at worst it's offensive and racist." (Sarra, 2007).

In reference to this case study, it can be argued that the CEO used the "race card" to those people outside of the organisation to deflect criticism, and to manipulate them to accept any unusual behaviour and the lack of compliance with the standards. The Royal Commission noted that he "used his culture" to protect him from scrutiny over many years (Royal Commission into Institutional Responses to Child Sexual Abuse, 2014a). In addition to using his Aboriginality with external agencies to avoid accountability, it is worth considering how he manipulated the staff and Board by encouraging a mistrust of other agencies. With the wounds of the Stolen Generations still so raw for many Indigenous people, it is possible to demonise the welfare system. This would further isolate staff and consolidate his own power and status and maintain his role as the only one who could manage relationships with those external to the agency.

So what is cultural competence? This needs to be, and is, an ongoing discussion and probably too large a topic to be finalised here. It seems that what is required is a sophisticated balance of knowledge, understanding and awareness with high expectation for success. It is also the case that Indigenous people cannot be the only ones responsible for cultural competence, as Sarra says we all need to be "... deeply committed to challenging ways of thinking and behaving that ... (are) unhelpful and contrary to the conduct of a high expectations relationship. It does not serve any of us to leave such ways of thinking and behaving unchallenged." (Sarra, 2007).

### Conclusion - What have we Learnt?

What we can learn from this case study is that there is a weave of systems and processes that are required to protect children and young people from institutional based abuse. The elements of the weave include the following:

## Well Designed and Evolving Organisational Systems and Processes

These systems and processes need to be embedded in governance with accountability, values and ethics, communication and knowledge sharing built in. There needs to be a culture of critical reflection – in which it is acceptable to ask questions and be critical of approaches of individuals (even the CEO) and of systems. The systems have to include policies that are available to all members of the organisation — the Board, staff, carers and children and families. Relationships should be encouraged with a range of significant adults in a child's life, including their birth families where possible. There needs to be ongoing knowledge and understanding of, and compliance with, existing standards and guidelines. There needs to be a genuine commitment to learning and development.

## High Level Knowledge and Skills and a Trauma Informed Approach

There needs to clinical competency including knowledge and skills in relation to all aspects of children's development

and care; and specialised knowledge and skills relating to child protection and OOHC. Recent research and evidence about the impact of, and approaches to, trauma should be considered core to practice in every OOHC agency. High level clinical competence should be sought and encouraged, with all staff encouraged to learn and be involved in reflective practice as part of regular supervision contributing to this.

#### **Cultural Competence**

System-wide cultural competence is required, including all the organisations involved in OOHC and for all workers providing child and family welfare services. All practitioners, Indigenous and non-Indigenous, should work towards high level awareness of cultural issues and providing culturally informed practice. This not only means accepting and encouraging Indigenous workers to identify cultural issues and approaches to ensure Indigenous children do not lose their culture or their identity. It requires non-Indigenous workers to proactively take on the responsibility for addressing the past and present racism and work towards genuine collaboration with Indigenous workers and families. It also means that non-Indigenous workers should accept "... the challenge ... to show the courage not to run when we play that race card so readily. If your questions are in fact legitimate, in the interest of high expectations, call our bluff and hold us to account" (Sarra, 2007).

Oversight agencies, funding bodies, non-Indigenous and Aboriginal specific organisations and individuals working in OOHC, all need to take up this challenge to ensure that culture never trumps safety. It requires the weaving together of all these "threads" to provide a strong enough fabric to protect children and young people in care.

#### A Final Note

In writing this case study, the authors observed that there seems to be limited research published on the impact of perpetrators on the workers in organisations. We hope the Royal Commission into Institutional Responses to Child Sexual Abuse is able to make recommendations in relation to this. Of course, priority focus should always be on the children and young people who were abused by people in an "organisational role"; however, there is also room for more research and development of practice to support the non-perpetrating workers who have also been traumatised, who have worked in those organisations.

The authors would like to thank the former workers of the service examined in this case study. We appreciate the opportunity to have worked with you during this difficult time and acknowledge all the positive work that happened despite the issues you faced.

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